

Spend-Down Expense Support

Process & Procedure Guide

Document Controls

Document Purpose

The Department performs the tasks of receiving and processing medical expense verification documents that are submitted by HUSKY consumers in order to meet their determined amount. Once a consumer appears to have submitted sufficient expenses to meet their spend-down amount, the information is referred back to the Department of Social Services (DSS). This guide describes in detail the steps that Screeners follow in completing the process for spend-down HUSKY consumers, whose income is too high to qualify for HUSKY under the regular medical assistance eligibility rules.

Intended Audience

The expected audience for this document includes:

1. DSS Management
2. Operational trainers
3. Operational staff as required

Version Control

Version	Date	Author(s)	Change
1.0	10/01/2018	Jose Martinez Fran Kula	Initial ImpaCT draft to replace prior version that used a third-party scanning, workflow and tracking solution.

Key Reviewers

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Table of Contents

- Document Controls 2
 - Document Purpose..... 2
 - Intended Audience 2
 - Version Control..... 2
 - Key Reviewers 2
 - Document Sign Off 3
- Process Overview 6
 - High Level Description..... 6
 - Three Major Tasks 6
 - DSS Initial Eligibility Processing..... 6
 - Spend-Down Screeners Medical Expense Processing..... 7
 - DSS Completes Final Spend-Down Eligibility Determination..... 8
 - Spend-Down Screener Task Overview 8
- Preparing to Process a Spend-Down Document 9
 - Preparing to Process the Spend-Down Document.....10
 - Recording Client Data on Worksheet.....10
- Screening the Expense Document.....11
 - Identify the Initial Expense Information11
 - Exception Process for Expenses Requiring Doctor Verification13
 - Tracking Forms and Expenses Received from DSS14
- Determining the Expense Type15
 - Identify the Expense Type17
- Screening for Ineligible Expenses18
 - Determine if the Client is a Member of the Assistance Unit’s Needs Group19
 - Determine if the Medical Expense is paid and was Incurred Prior to the Current Spend-Down Period.....20
 - Determine if the Client was eligible for Medicaid on the Date of Service.....20
 - Determine if Medical Expense was used in Prior Spend-Down Period.....21
- Confirming Third Party Liability (TPL) Payments are Billed and Applied.....21
- Provider-Related and Service Type Specific Procedures23
 - Provider-Related Procedures23
 - Providers Who Refuse to Disclose Information23
 - Bills/Claims from Hospitals.....23
 - Hospital Expenses for Consecutive Days during the Spend-Down Period.....23
 - Medical Expenses on Consecutive Dates Prior to the Spend-Down Period.....23
 - Expenses from Medical Providers Lacking the Type of Expense24

Handwritten Provider Statements/Invoices.....24

Service Type Specific Procedures24

Receipts for Purchase of a Product.....24

Receipts for Purchase of Prescriptions24

Prescription Expenses for Medicaid Recipient Members of the Needs Group25

Receipts for Medical Insurance Premiums25

Methadone Expenses26

Home Care Services.....26

Transportation Expenses27

Determining Acceptable Expenses and Applicable Expense Amount.....27

Entering Worksheet Information into ImpaCT.....27

 Special Medical Expense Considerations.....27

 Final Disposition of Expenses27

Process Controls.....27

 Quality Assurance and Quality Control27

Appendix A – Outgoing Calls Desk Guide29

Appendix B – ImpaCT Medical Coverage Groups31

Process Overview

High Level Description

Individuals and Families can potentially qualify for HUSKY A, HUSKY C and/or HUSKY D as “categorically needy” if their income is less than a specified income limit for the eligibility coverage group that applies to them. For example, the categorically needy income limit for families with children is 201% of the Federal Poverty Level (FPL) and for pregnant women it is 263% of the FPL.

An individual who is aged, blind or disabled (if not federally deemed disabled, may be found disabled by state medical review), or a child under 19 years or parent/care taker of a child who is under 19 years old and living with child, has income above the categorically needy income limit may qualify as a “medically-needy” HUSKY participant if their income is less than the Medically Needy Income Limit (MNIL), or if they “Spend-Down” to this income limit by offsetting their income in excess of this income limit, with incurred medical expenses. This is similar to a deductible in a private medical insurance plan, where the insured is responsible for the initial medical bills to meet the deductible, and the coverage begins when the deductible is met. The difference from regular insurance deductibles is that the HUSKY/Medicaid deductible (Spend-Down amount) is different for every case, as it is based on how much countable income is above the income limit. The Spend-Down process involves assuring that the assistance unit has incurred medical bills sufficient to meet the Spend-Down amount (deductible) before authorizing coverage under HUSKY A or HUSKY C.

The MNIL amounts are published by the state and are specific to one of the three regions of the state based upon where the applicant/recipient lives.

Three Major Tasks

There are three major tasks in the Spend-Down process. Department of Social Services (DSS) eligibility workers perform the first and third tasks, while Spend-Down Screeners perform the second task.

DSS Initial Eligibility Processing

DSS eligibility workers determine the amount of applied income for each medically needy assistance unit and the Spend-Down amount (if any) that applies. The Spend-Down amount is

determined on a six-month basis beginning with the month of the initial application for assistance (or less commonly, beginning with the first month in which there is Spend-Down eligibility, when the applicant is not potentially eligible in the initial month of application). For those previously in an established Spend-Down (either active or still in Spend-Down status) a subsequent six-month “period of eligibility” is established for those who complete the redetermination (renewal) process. DSS also determines that the assistance unit meets other non-financial (e.g. citizenship, Social Security Number) and financial (asset limit) eligibility requirements for HUSKY before referring the Spend-Down cases to the Spend-Down Processing Center to perform its part of process. The assistance unit is essentially determined to be eligible for HUSKY A, HUSKY C or HUKSY D, except that it needs to meet the Spend-Down before coverage can begin. The DSS worker places the case under Spend-Down (M) status in ImpaCT.

For new applications (not for redeterminations/renewals), DSS workers may also determine Spend-Down eligibility for one or more months via retroactive coverage, which includes the three months prior to the month of application. DSS will handle the entire process for these retroactive periods. However, Spend-Down Screeners should be aware that medical expenses may be applied to these retroactive months, and consumers may not use these same medical expenses again in the subsequent six-month Spend-Down periods of eligibility.

Spend-Down Screeners Medical Expense Processing

Spend-Down Screeners perform the second major task of the process. They receive and process medical expense verification documents submitted by HUSKY clients in order to meet their Spend-Down amount. These tasks are described in detail below. The Spend-Down Screeners review the medical expense documents submitted by the client, provider, or forwarded by DSS with one of the following potential outcomes:

1. The expense is not eligible to be used toward the Spend-Down amount. A notice is issued informing the client of this and the reason it cannot be used.
2. The expense document is missing information needed to make a determination of whether or not it can be applied to the Spend-Down amount. The client or provider may be called to request the missing information and a Request for Information (RFI) letter is sent to the client asking for the missing information.

3. The expense is determined to be eligible to be applied to the Spend-Down amount, but the client does not yet have sufficient expenses to meet their Spend-Down total, and thus qualify for coverage. A notice is sent to the client informing him or her of this, along with the Spend-Down amount remaining.

4. The expense is determined to be eligible and applied for Spend-Down, the client appears to have met the Spend-Down amount, and may become eligible. DSS is notified of this potential eligibility, so they can perform the third and final task of the Spend-Down process.

DSS Completes Final Spend-Down Eligibility Determination

For the third and final major task in the process, DSS workers are responsible for making the final eligibility determination and authorizing the met Spend-downs in ImpaCT which triggers a transaction to the Medicaid Interchange system. Coverage begins on the date that the HUSKY client incurs enough medical expenses to offset his or her excess income. Eligibility continues through the end of the six-month Spend-Down “period of eligibility.”

Spend-Down Screener Task Overview

HUSKY applications that result in determinations of Medicaid Spend-Down status are immediately sent from the ImpaCT are immediately sent from the eligibility system, a “Welcome Packet” consisting of a letter explaining the Spend-Down process, a Personal Medical Expense Tracking form to keep track of their medical expenses, and one return envelope with the cover sheet. that will result in the expense being scanned in and indexed as a Spend-down work item and routed directly to the Spend-down work task queue.

When the Spend-Down client submits copies of their medical expenses, the expense documents are imaged, and a Spend-Down workflow entry is generated in ImpaCT for processing by Spend-Down Screeners.

The Spend-Down Screener process involves using the ImpaCT system data concerning the assistance unit to determine how medical expenses are to be applied to the Spend-Down. This involves assessing whether the expense submitted on the document:

- Is an allowable expense type?
- Is a current bill that the assistance unit is obligated to pay?

- Is paid or unpaid, which, based on whether the expense was incurred or paid during the current Spend-Down period, determines whether it can be used,
- Is an expense type that requires a doctor's verification?
- Whether there is third-party medical insurance coverage for the bill, if the third-party payment has been applied, and whether the bill has already been used to make the client eligible for Medicaid in a prior Spend-Down period.
- How much, if any, of the expense can be used toward meeting the applicant's Spend-Down obligation, and the order in which submitted expenses will be used to meet the Spend-Down.
- Whether a Request for Information (RFI) must be sent to the client to clarify or verify any required information missing from the submitted document.
- Whether a notice must be sent to the client as notification that the submitted expense cannot be used toward their Spend-Down.

The Spend-Down Expense Worksheet is completed for all of the submitted expenses that qualify towards meeting the Spend-Down for a given assistance unit. The Spend-Down Screener then updates the ImpaCT system with the allowable expenses that can be used toward meeting the Spend-Down. DSS is then notified through an overnight batch the alert process in ImpaCT.

The following will detail all of the specific Spend-Down Screeners' procedural steps for the functions summarized above.

Preparing to Process a Spend-Down Document

This section describes the initial steps the Spend-Down Screener completes in preparation for processing a Spend-Down medical expense document. It involves using data from the ImpaCT system. Data concerning the Eligibility Determination Group (EDG) is taken from the medical expense document and the ImpaCT system and recorded on the Spend-Down Expense Worksheet. This is done in order to document the determination of how the medical expense(s) has been applied to the Spend-Down. The worksheet also allows screeners to capture document information that may be needed to update fields in ImpaCT.

Preparing to Process the Spend-Down Document

1. Log in to ImpaCT and access Task Inbox under the Task Management menu. In order to have the system assign a task, screeners will click on Next Task.
2. Click on Case Number to evaluate the “Currently Associated Programs.” Identify whether or not there is Medicare coverage and/or any other medical insurance coverage the client may have. This will be helpful when completing the “Confirming TPL has been Applied” procedure or, if there is no TPL coverage, it will allow Spend-Down Screeners to
3. Click on “Override” under the Eligibility Determination menu in order to assess the consumer’s Spend-Down period. Identify the current Spend-Down period, if applicable, and note the period, amount, remaining amount, and effective-date of coverage if met.
4. Click on the Coversheet link from the assigned inbox task and assess all expense documents received. Each document must be viewed to allow system closure of the task.

Recording Client Data on Worksheet

1. Screeners will update the Spend-Down Expense Worksheet with the following data from the assigned task and consumer’s case in ImpaCT:

Spend-Down Expense Worksheet Field	Spend-Down Detail Screen Field
Client ID #	ImpaCT ID of Individual who Received the Service from Household Members list
Name	Name of Individual who Received the Service from Household Members list
Coverage Grp.	MA Coverage Group Code
Spend-Down Period Begin Date	Begin Date

Current Spend-Down End Date	End Date
Document Received Date	
Task Create Date	
Task ID Number	
Net Spend-Down Amount	

At this point, the Spend-Down Expense Worksheet is ready to begin medical expense processing, as described in the subsequent sections. The worksheet will be updated with the expenses that are determined to be eligible towards the Spend-Down amount. The final results will then be transferred from the Spend-Down Expense Worksheet to ImpaCT.

Screening the Expense Document

Once the expense document has been opened from the workers inbox, the document screening process begins. This entails identifying necessary information from the expense document. This step is critical, since the information obtained from the expense document will be used in subsequent procedures to determine if the expense qualifies to be used toward the Spend-Down.

Identify the Initial Expense Information

1. From the Expense Document, review to identify the following initial information that will be used to determine if and how the expense may be applied to the Spend-Down:
 - a. Name of the person incurring the expense.
 - b. Date the service/purchase was incurred.
 - c. Date of the statement/letter or the purchase date.
 - Below are the different types of expense documents submitted for consideration, according to the Medical Expense Type language in the ImpaCT system:
 - Adult Daycare/Childcare

- Attendant/Health Aid
 - Cash Option Payment Received Medical
 - Cash Option Payment Received SNAP
 - Dentures/Dental Work
 - Health Insurance premium
 - Hearing Aids/Prosthetics
 - Homemaker/Housekeeper
 - Lab fees
 - LTCF Cost of Care
 - LTCF Private Rate
 - LTSS Conversion only
 - Medical/Hospital Care
 - Medical Marijuana (Medical only)
 - Medicare Part C Premium
 - Medicare Part D Premium
 - Prescription / Nonprescription meds
 - Purchase or Rental of Medical Supplies
 - Service Animal Costs
 - SNAP FSDE – other (Conversion)
 - Transportation /Lodging
 - Vision Care/Glasses
 - Vitamins/Supplements Approve by Physician
 - X-rays
 - Other
 - Medical Only (Policy Approved)
2. If the Expense document does not have all of the required information:
- a. Send a Request for Information (RFI) letter requesting the missing information.
Refer to [Appendix A: Outgoing Calls Desk Guide](#) for the circumstances where an RFI letter is required and when a call to the client or provider is sufficient.
 - b. Proceed to the next expense document for the client.
 - c. Case comments are required in ImpaCT prior to completing the inbox task.

Exception Process for Expenses Requiring Doctor Verification

3. A doctor verification must be provided (or currently on file) to confirm that the service or supply is medically necessary if it is determined that the medical expense is one of the following:
 - a. A home and community –based service not otherwise covered by the Medicaid program, such as:
 - Adult Day Care
 - Homemaker/Companion Service
 - Chore-person
 - Meals-on-Wheels
 - Personal Response Device Service
 - Other non-medical home and community-based service (Doctor verification is not needed for Skilled Nursing, Visiting Nurses, Physical and Occupational Therapy, or Home Health Aid/ Care services.)
 - b. Remedial Expenses (Service Dogs, Home Modification, etc.) – Home Modifications can be considered remedial expenses for Spend-Down. However, we must obtain a letter from the client’s physician verifying the modifications are medically necessary. Bring any such cases to the Lead or Supervisor’s attention.
 - c. Vitamins/Supplements
4. Exception: the services provided under the state-funded Home Care Program for Elders (coverage group M03) do not require a doctor letter. Medical necessity is established for all services provided under this program and thus it is not necessary to document it separately. Both the client-share and state-share of expenses covered by this program may be used toward the Spend-Down. The provider may need to be contacted to secure the amount paid by the state.
5. Determine if doctor verification has been previously provided:
 - d. If there is no doctor verification information provided, check ImpaCT case comments and review to determine if doctor verification is on file. Prior doctor verification is valid for one year.

- e. If ImpaCT case comments indicate the doctor verification has been previously provided, the expense may be used toward the Spend-Down.
- f. Send the client a Request for Information (RFI) letter requesting the doctor verification regardless of whether or not the provider or client is reached by phone.

Tracking Forms and Expenses Received from DSS

If the expense document is one that has been forwarded from DSS, includes the DSS cover sheet, and the expenses have been entered in ImpaCT by the DSS worker:

1. Do not send a letter to the client.
2. Add a case comment in ImpaCT, referencing the expense received date, stating that no action was required.

Although the type of Expense Document will vary, the following information may be found on most documents:

Section	Section Contents	Description
1	Provider Information	<ul style="list-style-type: none"> • Provider Name • Provider Address
2	Return Service Requested	<ul style="list-style-type: none"> • Return Phone Number • Return Contact Name • Return Address
3	Patient Information	<ul style="list-style-type: none"> • Name • Address
4	Statement Information	<ul style="list-style-type: none"> • Statement Date (Date of the Expense Document) • Amount Due from Payer (Insurer) – may include amounts from previous services not listed but charged to the insurer • Amount Due from Patient- may include amounts from previous services not listed) • Account Number
5	Services Provided	<ul style="list-style-type: none"> • Date of Service

		<ul style="list-style-type: none"> • Procedure Code • Diagnosis Code • Description of Service • Charges • Payments
6	Account Balance	Total amount of unpaid charges - may include amounts due from previous services not listed and from charges to insurer not yet paid.
7	Due From patient	Total amount due from patient - may include amounts from previous services not listed.

Determining the Expense Type

The Expense Type is a required element in the Expense Review process. It is used to determine whether the Spend-Down amount can be offset by the medical expense submitted on a particular expense document. The Expense Type is determined by reviewing the information from the expense documents received.

The Expense Types are categorized as follows (chart below):

- **High (Category 1)** - Acceptable Non-Medically Related Expenses
- **Medium (Category 2)** - Medically Related Expenses Not covered by Medicaid
- **Low (Category 3)** - Medically Related Expenses Covered by Medicaid

Category	Expense Type
1- High	Adjustment Category 1
	HUSKY B Premium
	Co-Insurance
	Copay
	Deductible
	Insurance Premium
2 – Medium	Adjustment Category 2
	Bill from Non CMAP Provider
	State Funded Home Care Program for Elders (MO3) Programs
	Medical Procedure Not Covered by Medicaid
Expenses recognized as medical costs but not covered by Medicaid in CT.	

Category	Expense Type
	Over the Counter Medications
	Over the Counter Supplies
	Remedial Expenses (Service Dogs, Home Modification, etc.) - <i>Verification from Dr. Required</i>
	Non-Medical Home Care Services for Non-M03 Clients – <i>Verification from Dr. Required</i>
	Vitamins/Supplements – <i>Verification from Dr. Required</i>
<p style="text-align: center;">3- Low Covered Medicaid Expenses</p>	Adjustment Category 3
	Ambulatory Surgery
	Audiology Services
	Behavioral Health Services
	Dental Services
	Dialysis
	Doctor Visits
	Durable Medical Equipment
	Emergency Care
	Eyeglasses
	Family Planning Services
	Hearing Aids
	Home Health Care
	Hospice Services
	Hospital Outpatient Care
	Hospital Stay
	Laboratory Tests
	Maternity Care
	Medical Transportation
	Orthotic and Prosthetic Devices
	Other
	Pharmacy
	Physical/Occupational/Speech Therapy
	Physical Rehabilitation
Preventive Care	
Vision Care	
Women's Health Care	

Category	Expense Type
	X-rays and Other Radiology Services

The information gathered at this stage of the process will be used later to enter into the ImpaCT system, if it is an expense that can be used toward the Spend-Down. When the Expense Type is entered into ImpaCT, the expense lines will be automatically sorted by their priority (High, Medium, and Low). ImpaCT has been programmed to use the expenses in the priority order listed above, however, it is still important to try to enter the expenses in the priority order, as it may not be necessary to enter some of the most recent expenses if the Spend-Down is met by Category 1, Category 2 and older Category 3 expenses.

If the expense submitted on the document is not one of the types listed, it may not be used toward the Spend-Down.

Identify the Expense Type

1. Review the Expense Document for information regarding the type of service or product received on the Date of Service to identify the Expense Type. If the description of the service or product received is not clear on the Expense Document, send the client an RFI letter to request it.
2. Make note of the Expense Category (1, 2, or 3) and the Expense Type using the chart above.
3. Prior to rejecting any expenses for services that are not considered typical medical expenses, bring the expenses to the attention of a Supervisor. Particularly if the client submitted a letter from a physician stating the expenses are related to a medical condition.
4. The cost of insurance to repair or replace a hearing aid or dentures is not considered a medical expense. However, if the client pays out-of-pocket towards the actual cost of replacement or repair, that is an acceptable medical expense.
5. If the expense document does not include an allowable medical expense type:
 - a. Stop processing the unallowable expense and send an RFI for that expense.
 - b. Process the next expense for the client.

- c. If there are no other expense documents, perform the medical expense close-out activities.
6. Non-Applicant Spouse Exception – If the member of the needs group who incurred the medical expense is the spouse of the applicant and the spouse is not a Medicaid applicant or recipient (a non-applicant spouse - financial responsibility code NR), and the expense is for a medical service covered by Medicaid, the expense should be coded as a Category 2 rather than Category 3 expense. Since the spouse is not an applicant or recipient, these expenses are a Medically Related Expense not applicable towards Spend-Down.

Screening for Ineligible Expenses

This section describes a series of steps that should be performed to determine if the submitted medical expense is not applicable towards the Spend-Down. These process steps will help screen out certain expenses and includes:

- Expenses incurred by an individual who is not a member of the Needs Group,
- Expenses incurred while the applicant was eligible for Medicaid,
- Medical expenses covered by Medicare for applicants who are Qualified Medicare Beneficiary (QMB – Q01 coverage group) recipients,
- Medical expenses incurred prior to the Spend-Down period that have been paid, and
- Expenses that have been used previously in a Spend-Down that resulted in the client being determined to be eligible.

The EDG sometimes includes members whose circumstances are not used to determine the client's Medicaid Spend-down eligibility. These individuals have a financial responsibility code of Non-member (NM) or SSI Child (SI). The most common circumstance where this occurs is when there is an adult head of household for a HUSKY A EDG who is not a parent and is not seeking coverage for themselves and is therefore given Non-member status. In addition, children who are SSI recipients may qualify in their own EDG and will therefore usually not be included in a Spend-Down EDG. Medical expenses for these individuals may not be used toward the Spend-Down.

QMB recipients, in addition to having their Medicare premium paid by Medicaid, are also eligible for coverage of their Medicare copays and deductibles that are not paid by Medicare. Federal law (Section 1902(n)(3)(B)) of the Social Security Act) provides that Medicare providers may not “balance bill” QMB recipients for these cost-sharing charges. As a result, a QMB-eligible client is not liable for the Medicare Part A or B copays or deductible amounts and therefore, these non-existence costs cannot be used toward a Spend-Down. QMB recipients are automatically eligible for the Medicare Part D Pharmacy Extra Help program, where the Medicare D premium is paid, and recipients only have to pay a small co-payment. These co-payments can be applied toward the Spend-down.

Medical expenses incurred prior to the current Spend-Down period are only allowable toward the Spend-Down if they remain unpaid and the client is liable to pay them, or if they were paid during the current Spend-Down period. Expenses incurred during the current Spend-Down period are allowable regardless of whether they are paid or unpaid. Therefore, it is important for any bills incurred prior to the Spend-Down period to have a current statement (within 30 days of the expense document’s Date Received) to confirm the client’s liability. The liability must be either directly to the provider or to a lender for a loan (including credit cards) that was used to pay off the expense. Expenses referred to a collection agency are also permissible to count toward the Spend-Down. Only the charge for the medical service for which the client is currently liable is allowed. Additional charges, such as interest or other fees, may not be used toward a Spend-Down.

Determine if the Client is a Member of the Assistance Unit’s Needs Group

Only members of the Spend-Down EDG’s Needs Group (i.e. those whose income is included in the Spend-Down calculation) are permitted to have their medical expenses used to establish eligibility under a Spend-Down. This procedure describes the process to confirm that the individual who incurred the medical expense is included in the needs group.

1. Identify the individual who incurred the medical service listed on the expense document.
2. Navigate to the consumer’s case and assess the Active Case Members section, which includes a list of all active members for the EDG. Conduct this search by navigating to the Individuals Search Screen, click on the Client ID and all Current EDG affiliations screens will display. Find Program type MA-S99-ABD, any household member who has

Participation Status of “eligible” or “counted” is included and the needs group and may have their Medical expenses applied, if expenses meet all the other rules described.

If the Participation Status is Ineligible, the individual is not a member of the needs group and his or her expenses may not be used toward the Spend-Down. Perform expense document close-out activities.

Determine if the Medical Expense is paid and was Incurred Prior to the Current Spend-Down Period

1. Review the expense document to determine if the medical expense is paid.
 - a. If yes, review the document to determine if the date of service for the expense is prior to the current Spend-Down period.
 - b. If yes, determine if the payment was made prior to the current Spend-Down.
 - If yes, the expense is ineligible to be used in the Spend-Down. Complete expense close-out activities.
 - If no, (the payment was made during the current Spend-Down period) the expense may be able to be used toward the Spend-Down, assuming it passes the other tests described below.
2. If no, (the medical expense appears to be unpaid) determine if the medical bill is current. Is the date of the statement during the Spend-Down period or within thirty days of the Expense Document “Date Received”?
 - a. If yes, the bill may be accepted and may be used toward the Spend-Down, assuming it passes the other tests described below.
 - b. If no, place a call to the provider to confirm the client liability.
 - c. If unable to confirm the liability with the provider, send a request for information to the client to request a current statement to confirm that the bill remains unpaid and perform expense close-out process steps.

Determine if the Client was eligible for Medicaid on the Date of Service

1. Identify the date of service for the medical expense.

2. Review the ImpaCT Override-screen to determine if the client was eligible for Medicaid in a full benefit coverage group (not QMB, SLMB, ALMB, TB or Family Planning, and not a State-funded coverage group) on the date of service. (See the chart below for a list of full benefit Medicaid coverage groups, limited benefit Medicaid groups and State-funded groups.) To be considered eligible in a Medicaid Spend-Down (_99) coverage group the EDG status must have an Approved Eligibility Status on the date of service.
3. If yes, is the expense one that would be covered by the Medicaid program?
4. If yes, the expense is ineligible to be used in the Spend-Down. Complete the expense close-out activities.
5. If no, the expense may qualify to be used if it passes the other tests described below.
6. Note: If the expense is for a client who has an active Spend-Down for the current or a prospective period and the expense may change the activation date, escalate the case to the Supervisor/ Manager and move on to the next case. Leave a case comment indicating that client has an active Spend-Down and the case was referred to the Supervisor/ Manager. Do not close the task or enter/remove any bills from ImpaCT. Screeners will select the “Return to Workpool” task action.
7. If the client has an active Spend-Down for the current or prospective period and the expense was incurred while the client was active, send an RFI notice advising the client that this is an “old bill – active HUSKY.”

Determine if Medical Expense was used in Prior Spend-Down Period

Review the Period data for prior period under the Spend-Down Override screen in ImpaCT. If the consumer has a date under Effective Date of Coverage, this means the period was met and prior expenses should be assessed. Screeners will click the Action pencil link and view the prior expenses to see if the expense(s) received was previously used to qualify the client for that Spend-Down period.

Confirming Third Party Liability (TPL) Payments are Billed and Applied

Any portion of the expense used for the Spend-Down cannot be payable through third-party coverage, unless the third-party coverage is a public assistance program totally funded by the State of Connecticut or by a political subdivision of the state (e.g. payments made by the State

Homecare Program for Elders). Only the portion of the expense not paid by a third-party can be applied to a Spend-Down (i.e. deductibles, copayments and co-insurance, or expenses not covered by the insurance product). When there is third-party coverage the medical expense must have been processed through the third-party payer before it can be used in a Spend-Down.

If the client has coverage under the Qualified Medicare Beneficiary (QMB) program (Q01 coverage group), then the state pays the Medicare premiums. The client is not responsible for paying Medicare cost-sharing as described previously in the Screening for Ineligible Expenses procedure. Thus, these expenses cannot be used to meet the Spend-Down obligation

If the client has coverage as a Specified Low-Income Medicare Beneficiary (SLMB - Q03 coverage group) or as an Additional Low-Income Medicare Beneficiary (ALMB - Q04 coverage group), the state pays the Medicare Part B premium and thus these premiums cannot be used toward the Spend-Down. However, unlike QMB, the client is likely to be responsible for Medicare cost-sharing and thus Medicare deductibles and co-insurance charges can be used toward the Spend-Down.

If the client has third-party medical insurance coverage the claim must be processed by insurer before the bill can be used toward the Spend-Down, as we must confirm the amount paid by insurance and only use the portion of the bill that is not covered by the insurance carrier toward the Spend-Down.

If ImpaCT indicates that there is TPL coverage that matches the type of service reflected on the bill, but the bill does not reflect any third-party payment, do the following:

1. send an RFI letter to the client advising him or her that the medical insurance claim must be submitted to the insurer and any third-party payment applied before the expense can be applied to the Spend-Down.
2. If the client indicates that the third-party coverage no longer exists:
 - a. Client must secure verification of the policy termination and submit it.
 - b. Any such termination notice must be forwarded to the DSS TPL Unit so that the TPL status can be updated in ImpaCT.

Provider-Related and Service Type Specific Procedures

This section addresses some topics concerning reviewing medical expense documents from specific types of providers and medical services, and dealing with providers, in general.

Provider-Related Procedures

Providers Who Refuse to Disclose Information

Bills/Claims from Hospitals

Claim forms are acceptable as long as we have the following information:

- The print out has the documentation for date of service.
- The client incurred the expense and is still liable.
- A breakdown of daily charges

If the above information is known the claim form is acceptable and an updated bill is not necessary. This is considered acceptable documentation of incurred expense and the expense can be added under category 3 as unpaid, services covered by Medicaid.

Hospital Expenses for Consecutive Days during the Spend-Down Period

When a hospital expense document or claim form is for a hospital stay spanning multiple days, it must be divided into separate expenses by day. The date of service for each expense line will be the actual date of the day the services were provided.

If a portion of the hospital bill is all that is needed to meet the Spend-Down, it is only necessary to break out the expenses by date of service up to the date when the Spend-Down is met. The ImpaCT narrative should be updated to indicate the dates and remaining amount of any part of the bill that is not used for the current Spend-Down, as this can be used toward a future Spend-Down if it remains unpaid.

Medical Expenses on Consecutive Dates Prior to the Spend-Down Period

If a bill that has multiple consecutive dates of service is unpaid and is dated in a period prior to the Spend-Down period being considered for entries (and was not used in a prior Spend-down period), there is no need to require a daily breakdown. Use the first day of the consecutive dates

of service period and combine the whole bill when applying it to the Spend-Down. It is not necessary to request a bill with a breakdown of dates. Include in the notes section of the bill entry the actual dates of service. This information should also be recorded in the ImpaCT narrative with reference any portion of the bill that is not used to meet the Spend-Down so that it may be applied to a future Spend-Down.

However, if the bill, whether paid or unpaid, is dated within the Spend-Down period under consideration, require a daily breakdown so that the Spend-Down can be activated on the correct date.

Expenses from Medical Providers Lacking the Type of Expense

If the bill is from a medical provider, it can be assumed that it is a medical expense and can be used even if the specific service provided is not indicated on the bill. When entering the expense type in ImpaCT, use the code that is appropriate for the type of provider.

Handwritten Provider Statements/Invoices

Upon receipt of a handwritten provider statement/ invoice, contact the provider to find out if this is the standard method of billing. If it is on an official document from the business accept it. If it is not the standard way the provider bills all the clients in the practice, send an RFI to the client. Document all calls made to the provider.

Service Type Specific Procedures

Receipts for Purchase of a Product

When the expense document is a Receipt for a purchase of a product (e.g. aspirin):

1. If the Name is not present, then the AU HOH Name may be used, and the expense may be applied to the AU HOH for general receipts (e.g. supplies, over-the-counter needs, etc.). Otherwise, a name is required and must be secured from the client with any required doctor's verification.
2. Use the Date of Purchase as the Date of Service (DOS).

Receipts for Purchase of Prescriptions

When the expense document is a Receipt for payment of a prescription:

1. A prescription related expense may be accepted without the name of the client if it is for less than \$25.00.
2. A prescription related expense for \$25.00 or more must have the name of the client on it.
3. If Spend-Down Screeners receives prescription receipts that do not indicate the name of the client and the prescription expense is \$25.00 or more, a “Request for Information” (RFI) notice should be sent to the client.
4. In the case of an emergency, the screener should try to contact the pharmacy by phone to obtain verification of the name of the client to whom the prescription was provided. Document the call with case notes indicating the name of the contact at the provider who verified the client that received the prescription and the date of the contact.
5. If the Spend-Down Screener is unable to contact the provider, or the provider refuses to verify the information, it is the responsibility of the client to meet the verification requirement.

Prescription Expenses for Medicaid Recipient Members of the Needs Group

Individuals who have Medicaid and Medicare D are considered Full Dual eligible. Medicare Part D pays all Medicare covered prescription drug copays in excess of \$15 per month for the Full Duals. Therefore, the max out of pocket prescription copay expenses allowed is \$15.00 per month for any spouse of the spend-down client. If the spouse has incurred copays less than \$15.00 for the month allow only the actual cost of the copays.

Receipts for Medical Insurance Premiums

When the expense document is a Receipt for payment of a premium or a bill for payment of a premium, proceed as indicated below:

1. **Insurance Premiums** – Use the first day of the Spend-Down Period as the Date of Service, or if the insurance began sometime during the Current Spend-Down Period; then use the date the insurance begins as the Date of Service.
2. **HUSKY B Premiums** – Access the Premium Processing System (PPS) and confirm the premium was paid and the coverage is in force. Use the date the premium payment was received by Premium Processing Center as the date of service.
3. **Medicare B Premiums** – For clients with Medicare B coverage who are not active recipients in a Medicare Savings Plan coverage group (Q01, Q03, or Q04),

- a. Automatically apply the Medicare B premium to the Spend-Down for the six-month period by multiplying the monthly premium by 6 and recording the result.
- b. Adjust the calculation if the Spend-Down Period overlaps the beginning of year to account for the change in premium amount if the new premium is known.
- c. Use the premium amount shown on the ImpaCT screen. Some clients pay more than the standard premium if they enrolled in Medicare late.
- d. Use the first day of the Spend-Down Period as the date incurred.
- e. The entire amount should also be coded as paid expenses.

Methadone Expenses

Methadone maintenance expenses may be applied to a Spend-Down if the services are not provided in a hospital setting. These services are not covered by Medicare. Depending on the billing manner, different approaches are required by the Spend-Down Screener:

1. Some methadone maintenance providers are billing for services for the entire week, rather than each daily session. When applying the expenses, Spend-Down Screeners will use the last day of the week as the Date of Service (DOS).
2. If the services are provided in a hospital (inpatient) please note the service is covered by Medicare and the expenses must be submitted for TPL before applying them to the Spend-Down.

Home Care Services

All home care services should be entered in the period in which they were incurred. Whether or not they were paid doesn't matter, as long as they are the client's liability. If the expenses for six months of home care services do not activate the six-month Spend-Down Period, the remaining balance still owed as of the first day of the next Spend-Down Period could be applied to that new period. A call to the provider is required to verify what is still owed.

Transportation Expenses

Any transportation expenses need to be forwarded to a Lead or Supervisor, prior to applying them. We are still working with DSS to define which transportation expenses are acceptable for Spend-Down.

Determining Acceptable Expenses and Applicable Expense Amount

This section provides a summary of steps presented in the prior procedures to determine the expenses that can be used toward the Spend-Down amount and provides details on obtaining the correct amount from each expense to be applied to the Spend-Down total. The Spend-Down Screener will apply to the Spend-Down amount all expenses that have not been screened out as ineligible, in the amount remaining after any third-party liability payments have been taken into account. Expenses are applied to the Spend-Down amount in a specific order, based on the category of the expense, and the date of service.

Entering Worksheet Information into ImpaCT

Special Medical Expense Considerations

If Spend-Down Screeners receive a bill with a date of service within the Spend-Down period that will meet the Spend-Down, the line items don't need to be added up for that date of service that actually meets the Spend-Down. If the daily total is listed on the bill, it can be used, but if it's a bill that covers multiple days with numerous line items that are not totaled by day, the screener should use the earliest charge that will meet the Spend-Down, to activate the Spend-Down.

Final Disposition of Expenses

All Spend-Down medical expense documents that are scanned in ImpaCT must have an action taken in ImpaCT. This includes documents that may not truly be expense documents. Prior to closing, all Spend-Down tasks require a closing action.

Process Controls

Quality Assurance and Quality Control

The Quality Assurance (QA) team is primarily responsible for monitoring the quality of the work being produced by Spend-Down Screeners through comprehensive quality assurance

processes. The department ensures the delivery of high quality products and services and serves as a checks and balances for business practices and processes.

The department generates two reports, which capture all of the completed and pending cases for the prior work day. A minimum of twelve cases will be reviewed per pay period for each Spend-Down Screener. Scores under 96% are sent to the corresponding supervisor for review.

Appendix A – Outgoing Calls Desk Guide

RFI	Call Provider	Call Client	Send Letter?
Bill Already Used			X
Paid Bill Prior to Period			X
HUSKY Eligible for Date of Service			X
Qualified Medicare Beneficiary			X
Incomplete –What it is for	X		X
Incomplete Verification–Date Of Service	X		X
Not a Bill			X
Incomplete Verification- Who incurred the expense?	X		X
Premium Verification Request			X
Medical Expenses - Paid vs. Unpaid			X
Third Party Liability- Not billed			X
Third Party Liability in ImpACT			X
Current Medical Expense Verification			X
Vitamins/Supplements			X
Services Need Verification			X
Not current Bill			X
Incomplete Verification – Total Outstanding Balance			X
Ineligible Expense – Not An AU Member			X
Unacceptable Verification of Expense			X
Duplicate Expense Submission			X
Illegible Documents			X
Old Expenses Received and Client has Active Medicaid Coverage			X
Zero Client Liability			X
Closed			X
Provider Information Needed			X

RFI	Call Provider	Call Client	Send Letter?
Client's decision on SD Period		X	X
Unconfirmed Patient Liability			X
Home Care Expense Liability	X		X

Appendix B – ImpaCT Medical Coverage Groups

- **Full Benefit Medicaid Coverage Groups – Non- Groups**

Medical Coverage Group Code	Description
DO1	HUSKY A Children Receiving IV-E Payments
DO3	HUSKY A for DCF Non-IV-E Subsidized Adoption Children
DO4	HUSKY A for Child Living Foster Care
F03	HUSKY A Extended Medical Assistance due to Earnings
F04	HUSKY A Extended Medical Assistance due to Child Support
X07	HUSKY A for Parents/Caretaker Relatives
X25	
X25	HUSKY A for Children
X02	HUSKY D
H01	HUSKY A for Children Receiving Home and Community-Based Services
L01	HUSKY C Long Term Care Facility Residents Eligible under Special Income Level (CN)
M04	Medicaid for Individuals with Breast or Cervical Cancer
N01	HUSKY D Low Income Adult Long Term Care Facility Coverage (CN)
X01	HUSKY A for Categorically Needy Pregnant Women
X01	HUSKY A for Pregnant Woman Under 250% of Poverty Level
X01	HUSKY A Medically Needy Pregnant Women Under MNIL
R01	Recipients of Refugee Cash Assistance (RCA)
R02	Refugee Increased Earnings Extension (RMA)
R03	Refugee Medical Assistance – Income under Cash Income Standard (RMA)
R04	Refugee Newborns Medical Assistance
R95	Refugee Medical Assistance – Income under MNIL
S02	HUSKY C AABD Eligible Non-Recipients

S03	HUSKY C Eligible for AABD Except for non-Medicaid Requirements
S04	HUSKY C Severely Impaired
S05	HUSKY C Working Disabled
S95	HUSKY C Medically Needy Aged, Blind, Disabled under MNIL
T01	HUSKY A Children in Long Term Care Facilities (CN)
WO1	Federal Medicaid Home and Community-Based Waiver Coverage

- **Full Benefit Eligible Medicaid Coverage Groups – Groups**

Medical Coverage Group Code	Description
F99	HUSKY A Medically Needy Children and Families – -retro only
L99	HUSKY C Medically Needy Long Term Care Facility Residents
P99	HUSKY A Medically Needy Pregnant Women -retro only
R99	Refugee Medical Assistance –
S99	HUSKY C Medically Needy Aged, Blind, Disabled
T99	HUSKY A Children in Long Term Care Facilities (MN)

- **Limited Benefits Medicaid Coverage Groups**

Medical Coverage Group Code	Description
M05	Medicaid for Individuals with Tuberculosis – TB-related Services only
M07	Family Planning Coverage (Presumptive Eligibility) – Family Planning Services and Supplies only
MO8	Family Planning Coverage – Family Planning Services and Supplies only
Q01	Qualified Medicare Beneficiaries (QMB) – Medicare Premiums and Cost Sharing Only
Q03	Specified Low Income Medicare Beneficiaries (SLMB) – Medicare B Premium Only
Q04	Additional Low Income Medicare Beneficiaries (ALMB) – Medicare B Premium Only

- **State Funded Medical Assistance Coverage Groups**

Medical Coverage Group Code	Description
DO2	HUSKY A State-funded DCF Medical
D05	DCF Behavioral Health Services Only for non-HUSKY child
M03	State –Funded Component of the Connecticut Home Care Program for Elders